KENTUCKY BOARD OF
EMERGENCY MEDICAL SERVICES
COMMONWEALTH OF KENTUCKY
2545 Lawrenceburg Road, Frankfort KY 40601
Phone: (502) 564-8963 Fax: (502) 564-4687

Application for Paramedic Licensure Reinstatement

Fill in all Blanks that Apply:
Social Security Number: _____ Birth Date: _____ Sex (M/F) _____

Paramedic License Number: _____(Please provide a copy of card)

Name:_____
(Last Name) (First Name) (Middle Name)

Address: _____

City: _____ State _____ Zip Code _____

Home Phone: _____ Email address:_____

Name of Company Employed by:_____ Contact Person _____

Street_____ City _____ State _____ Zip Code _____

Work Phone Number: _____ Fax Number:_____

Date of Expiration:_____
Reason for Expiration: (Please provide a separate sheet of paper it needed)
_____

Office Use Only:
Check#_____
M.O.# _____
Amount $_____
Date Cert._____
Cert. # _____
Exp. Date _____

***All questions on this application must be answered. Failure to respond to these questions, this application shall be returned to you as incomplete*:**

1. Have you ever been convicted of a felony, pled guilty to a felony, entered into an alford plea to a felony, or participated in a diversion program for a felony? No____ Yes____
2. Have you ever been convicted of a misdemeanor or DUI? No____ Yes____
   (If yes, please provide a written explanation and a certified copy of court records).
3. Have you ever been cited for a moving violation while operating an emergency medical vehicle? No____ Yes____
   (If yes, please provide a written explanation).
4. Have you ever had a civil judgment entered against you arising from a situation(s) in which you were delivering or attempting to deliver medical care? No____ Yes____
5. Have you ever been in default on any school loans? No____ Yes____
   (If yes, please provide a written explanation).
6. Have you at any time had your certification(s) or registration(s) as a First Responder been restricted, revoked, denied, suspended or expired? No____ Yes____
7. Do you use drugs, alcohol, or other controlled substances to the extent that it may affect your ability to perform the duties of a first responder? No____ Yes____
8. Do you have a physical, mental or other disability for which you are requesting a medical restriction or special accomodation under the Americans With Disabilities ACT (ADA) or a condition that would prevent you from safely performing the duties of a first responder? No____ Yes____
9. If you marked yes on any of the above questions, have you reported this to the KBEMS office? No____ Yes____

I hereby certify that the information provided on this application is complete and true to the best of my knowledge. I understand that knowingly supplying false information on this application is a violation of KRS Chapter 311A and subjects me to the full range of disciplinary action described therein. I further understand that my application can be returned to me incomplete if I failed to provide all information requested on this application.

_____ _____
Signature of Applicant Date

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VERIFICATION OF COMPETENCY

Choose ONE method of verification

Method I:

"I do hereby verify the competency of the above applicant in reference to all skills required by the level of certificate or licensure requested by the applicant."

Medical Director	*Printed Name*
or~	
Ambulance Service Director	*Printed Name*
or~	
Ambulance Service Training Director	*Printed Name*

Method II:

Submit evidence of current registration as a:

NREMT-P

-OR-

One from EACH of the following:

1. ACLS
2. PALS or PEPP
3. BTLS, PHTLS, or CCEMTP